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ABSTRACT

The materials selected for this bibliography consist of documents generally published between 1965 and 1969, though some earlier and later works are included. Some of the references that are of particular interest are annotated. The bibliography which is particularly useful to graduate programs in family practice medicine is divided into six sections: (1) bibliographies; (2) general references for training programs; (3) research in family practice; (4) training in family medicine; (5) instructional and evaluative techniques; and (6) psychotherapeutic aspects of family practice. (AF)

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TRAINING FOR FAMILY PRACTICE

A SELECTED BIBLIOGRAPHY

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INTRODUCTION

Our goal in assembling this bibliography was to be of maximum service to graduate programs in family practice medicine. The material is grouped into six sections: Bibliographies; General References for Training Programs; Research in Family Practice; Training in Family Medicine; Instructional and Evaluative Techniques, and Psychotherapeutic Aspects of Family Practice. For each of these sections there is a brief introduction, but some general explanatory remarks may be helpful here.

All materials listed have been read and evaluated. Selected references of particular interest have been annotated. For every reference selected, approximately two were judged inappropriate.

Because of the rate of current accumulation of knowledge in the field, we have concentrated our search in the literature to the period from 1965-1969. There are references from the first half of 1970, but coverage during this period cannot be considered complete. Important contributions prior to 1965 have been included.

No unpublished material has been selected, nor any work in press, and the search was limited to books and journals in English.

Where journal names have changed, for example, The Journal of the College of General Practitioners to The Journal of the Royal College of General Practitioners, references have been listed according to the journal title at the date of publication.

Most often reports from official medical groups are listed under the name of the sponsoring organization.

Because we were concerned with graduate education in family practice, coverage of some areas of overlapping interest had to be curtailed. Thus, undergraduate and continuing education in family practice are not stressed, nor are the reports of the many new programs for doctors' assistants. Nostalgic and exhortative accounts have, in general, been omitted unless they contained concepts of value to residency training.

For the physician wishing to keep up with developments in this field, we recommend the new Abridged Index Medicus and a routine reading of the following journals: The Journal of Medical Education, The Journal of the American Medical Association, and The Journal of the Royal College of General Practitioners. For those interested in a more circumscribed topic, the above sources plus a Medlars Search by the National Library of Medicine might be useful.

This research has been funded by the Staunton Clinic, Western Psychiatric Institute and Clinic, and NIMH Grant No. 5 T15 MH 06808. We gratefully acknowledge the interest and support of the Society of Teachers of Family Medicine and the Educational Division of the American Medical Association. The assistance of Mr. Jeremiah A. O'Mara, M.S., Chief Librarian, Western Psychiatric Institute and Clinic, has been indispensable throughout the project, and many useful suggestions have come from colleagues and users whose number is too great to include mention here.

Our special thanks go to Mrs. Dolores Duda who helped to edit and type the final draft.

July, 1970

I. BIBLIOGRAPHIES

1. Altman, Isidore, Anderson, Alice J. and Barker, Kathleen. Methodology in evaluating the quality of medical care: an annotated selected bibliography, 1955-1968. (Rev. Ed.) Pittsburgh, University of Pittsburgh Press, 1969. 397 items.

2. Hammond, Margaret (Librarian). Bibliography: training for general practice. London, Royal College of General Practitioners, June, 1969. 298 items.

3. Riedel, Donald C. Utilization review: a selected bibliography 1933-1967. U. S. Department of Public Health, Education and Welfare, Public Health Service, Health Services and Mental Health Administration, Division of Medical Care Administration. Arlington, Va., 1968. 304 items.

4. Tenney, J. B. The content of medical practice: a research bibliography. Baltimore, Johns Hopkins University, Department of Medical Care and Hospitals, 1969. 211 items.

5. U. S. Department of Health, Education and Welfare, Public Health Service. Training methodology. Part III. Instructional methods and techniques: an annotated bibliography. 1969. 346 items.

6. U. S. Department of Health, Education and Welfare, Public Health Service. Training methodology. Part IV. Audiovisual theory, aids, and equipment: an annotated bibliography. 1969. 332 items.

II. GENERAL REFERENCES FOR TRAINING PROGRAMS

In this section we have gathered those works which might be useful to graduate training programs in family medicine. These references include: general considerations of medical practice, e.g., Balint (1951) and Engel (1969); provocative points of view, e.g., Silver (1963) and Holman (1969), and the literature dealing with methods for assessing the quality of medical care, e.g., Sidel (1966). Accounts of the history of general and family practice are also included--see Darley (1967), Horder (1969), and Richmond (1969).

7. Balint, M. The doctor, his patient and his illness. (Revised and enlarged, 2nd Edition) London, Pitman, 1964. 395 pp.

   This book is the first account of Dr. Balint's work with general practitioners. The author, a psychiatrist and a psychoanalyst, has described this enterprise as the discovery of a method of research-cum-training conducted within a seminar framework which allowed all participants to learn more about the psychotherapeutic aspects of medical practice. Developments stemming from work with the first group of 14 general practitioners led to a series of training, research and evaluative projects by other investigators (for example, Browne and Freeling, Clyne, and Greco and Pittenger). The third section of the book, which includes material on the apostolic function of the doctor, the doctor and his patient, the patient and his family, and general-practitioner psychotherapy, is of special interest for family practice.
   5 footnote references.

8. Balint, M. The other part of medicine. Lancet, 1, 40-42, 1961.

9. Balint, M. The doctor's therapeutic function. Lancet, 1, 1177-1180, 1965.

10. Beloff, Jerome S. and Willet, Marion. Yale studies in family health care. III. The health care team. JAMA, 205, 663-669, 1968.

    Authors' summary: "The Health Care Project is an experimental attempt to answer the need for a health care system which will bridge the gap between patient needs and available but fragmented health resources. The health care team, which consists of physicians, public health nurse, and health aide, coordinates the efforts of allied medical personnel to give comprehensive health care to multi-problem urban families. There are difficulties in creating a coordinated health team, given the traditional role of the doctors, nurses, and other health personnel. After two and one-half years of experience with this model, it was possible to develop an effectively

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10. Beloff, Jerome S. and Willet, Marion. JAMA, 205, 663-669, 1968 (Cont.)

functioning health team when communication techniques were improved. The data presented reveal the effect of health team delivery of care and utilization patterns of urban families." An example of the kind of health care utilization patterns revealed in the data are the following: for the first year, 48% of all patient contacts were for symptomatic reasons; the second year, only 28% of contacts were for this reason. When utilization data for 1,000 contacts from January to March, 1967, were studied, it was discovered that 47.1% of all contacts were in the home, most of these by public health nurses. 55% of all contacts were with the nurse and health aide, only 35% required physician attention. Preventive medicine, health assessment and supervision comprised over 60% of all contacts, compared with 25% for acute symptomatic medical care. 11 references.

11. Brown, Esther. Newer dimensions of patient care. New York, Russell Sage Foundation, 1965. 516 pp.

The chapter titles are good descriptions for each of the three parts of this book, and ample confirming evidence from social science studies is available throughout the book. Part I, The Use of the Physical and Social Environment of the General Hospital for Therapeutic Purposes, includes: Chapter 1, Patients are People in Trouble; Chapter 2, Patients' Perceptions and Expectations; Chapter 3, 'Things' as Familiar and Comforting Symbols; Chapter 4, Receiving the Patient into the Hospital; Chapter 5, Visitors and Visiting Hours; Chapter 6, The Therapeutic Role of Patient as Helper; Chapter 7, Effecting Change. In Part II, Improving Staff Motivation and Competence in the General Hospital, are included: Chapter 1, Psychological and Social Needs of Staff; Chapter 2, Small Work Groups; Chapter 3, The Formal Structure of the General Hospital; Chapter 4, Communication and Coordination of Patient Care; Chapter 5, Motivation; Chapter 6, Effecting Change--I; Chapter 7, Effecting Change--II. In the last part of the book, Patients as People, the author urges caretakers to consider a psychosocial and cultural frame of reference, including the importance of cultural, ethnic and socioeconomic factors for the patient, and implication of social class and ethnic background for health services. 280 footnote references (approx.).

II. GENERAL REFERENCES FOR TRAINING PROGRAMS

12. Browne, Kevin and Freeling, Paul. The doctor-patient relationship. Edinburgh and London, E. & S. Livingstone Ltd., 1967. 73 pp.

This book may be thought of as a psychological anatomy and physiology of the doctor-patient relationship. Among some of the more important concepts which the authors consider are the following: "Unorganized illness" is used to describe a situation one finds in many patients in stress who present the doctor with an illness as yet unidentified. The authors stress the importance of the practitioner working with the patient so that both may understand more completely the real nature of the illness. Conversely, they point out the importance of taking particular care to avoid requiring a physical symptom of the patient as a ticket of admission. A suggestion is also made that the doctor take full advantage of his own feelings in arriving at a diagnosis or therapy. "The patient who makes the doctor feel sick or angry is giving as much diagnostic information as the patient who is hot to the touch." Two chapters are used for a consideration of sympathy in practice, and they include its role in making therapy possible and the care which must be taken to administer this "drug" with thoughtful consideration. Concerning communication, the authors urge physicians to assume little about the accuracy or completeness of what the patient may be able to tell him at first, but to listen and observe more closely to enhance the communication. Also stressed is the importance of the family as a unit in medical practice and the persistence of early parental influences in all patients. 14 references by chapter.

13. Burns, C. An anatomy of general practice. J. Roy. Coll. Gen. Pract., 17, 137-143, 1969.

14. Clyne, M. Night calls. London, Tavistock Publications, 1963. 216 pp.

From the original group of 14 practitioners who worked with Michael Balint at Tavistock (see Balint, item 7) has come a series of researches of which this book is the first report. The author has focused on a special sector of medical practice, and has taken care to record data in considerable psychological detail. For example, Chapter 4, The Doctor's Response (to the night call), includes as subtopics: hostility, regression, preliminary diagnosis, bias, idealizations, and selection. There are 42 complete case examples and 32 additional clinical vignettes. In Chapter 7, The Interaction of Personality and Work, there are detailed descriptions of the work characteristics of each of the eight doctors in the research group. 52 references.

II. GENERAL REFERENCES FOR TRAINING PROGRAMS

15. Commission on Education, American Academy of General Practice. Continuation study requirements. GP, 35, 173-175, 1967.

16. Darley, Ward. Education for the practice of family medicine. GP, 32, 166-171, 1965.

17. Darley, Ward. The medical school and the practicing physician. Yale J. Biol. Med., 39, 395-403, 1967.

18. Darley, Ward. The hospital staff, community medicine, and continuing education. JAMA, 204, 590-594, 1968.

19. Darley, Ward and Somers, Anne R. Medicine, money and manpower--the challenge to professional education. II. Opportunity for new excellence. New Eng. J. Med., 276, 1291-1296, 1967.

20. Darley, Ward and Somers, Anne R. Medicine, money and manpower--the challenge to professional education. IV. New training for new needs. New Eng. J. Med., 276, 1471-1478, 1967.

21. DeGroot, L. J. (Editor). Medical care--social and organizational aspects. Springfield, Ill., Chas. C. Thomas, 1966. 538 pp.

In this book the editor has collected a number of papers originally published in the New England Journal of Medicine from July, 1963, through February, 1964, on the topic, "Medical Care: Its Social and Organizational Aspects." Of special interest to family medicine may be: Chapter 1, Jaco, E. G., Twentieth Century Attitudes toward Health and their Effect on Medicine; Chapter 6, Stead, A., Postgraduate Medical Education in the Hospital; Chapter 7, Bradley, S. C., Medical Education and Medical Research--An Interaction; Chapter 8, Miller, G. E., The Continuing Education of Physicians; Chapter 14, Silver, G. A., The Hospital and Social Medicine; Chapter 16, Anderson, O. W., Health-Service Systems in the United States and Other Countries--Critical Comparisons; Chapter 17, Bower, A. D., General Practice--An Analysis of Suggestions; Chapter 19, Peterson, O. L., Evaluation of the Quality of Medical Care; Chapter 20, Rosen, C. R., Health Needs and Resources in the United States, and Chapter 30, DeGroot, L. J., Further Comments on Medical Care.
316 references by chapter.

22. Donabedian, A. Evaluating the quality of medical care. Milbank Mem. Fund Quart., 44, 166-206, 1966.

This paper includes a discussion of virtually all the concepts essential to an understanding of evaluation of the quality of medical care. Three approaches to assessment of medical care

II. GENERAL REFERENCES FOR TRAINING PROGRAMS

22. Donabedian, A. Milbank Mem. Fund Quart., 44, 166-206, 1966 (Cont.)

are described. The pitfalls of using clinical records and the problems involved in direct observation are also considered. The value of empirical standards, derived from practice, and normative standards, derived from academic sources, are compared. The problems of reliability and bias among judges is given thorough attention and cited as an area where more research is needed. 70 references.

23. Dryer, Bernard. Lifetime learning for physicians: principles, practices and proposals. J. Med. Educ., 37, No. 6, Part 2, 1-134, 1962.

This is a report of a joint study committee appointed by the Board of Trustees of the American Medical Association. In addition to the AMA, the following organizations were included as sponsors: The Association of American Medical Colleges; The American Hospital Association; The American College of Physicians; The American Academy of Pediatrics; The American Psychiatric Association; The American College of Obstetricians and Gynecologists, and The American Academy of General Practice. Excerpts from the author's interpretive summary are perhaps the most adequate annotation. "The historical developments of medical education--coupled with the maldistribution of excellent opportunities for continuing medical education--limit most efforts to meet today's educational needs by the methods of yesterday. The fragmentation of postgraduate medical education support has the value of variety and a wide range of individual choices, but the defect of creating duplication and expensive waste of the doctor's time and money by educational efforts which are too scattered, too little or too late. A partnership among the proven abilities of several of our major medical resources will give strength to all which none can possess separately. This opportunity (for a partnership) can be realized with relative swiftness by setting it upon this firm tripod: (a) a re-examination of ideas as to what constitutes the true continuing education of a physician; (b) the translation of these ideas into an administrative partnership of our best available teaching resources; (c) the wide utilization of imaginative tools offered by modern technology to reinforce the teaching-learning process. This proposal is, in a sense, the design for a nationwide university without walls." 342 references.

24. Duffy, J. C. and Litin, E. M. The emotional health of physicians. Springfield, Ill., Chas. C. Thomas, 1967. 88 pp.

II. GENERAL REFERENCES FOR TRAINING PROGRAMS

25. Ellis, J. The future teaching of general practice. Brit. J. Med. Educ., 3, 23-27, 1969.

26. Engel, George L. Clinical observation: the neglected basic method of medicine. JAMA, 192, 849-852, 1965.

27. Engel, Gloria. The effect of bureaucracy on the professional autonomy of the physician. J. Health Soc. Behav., 10, 30-41, 1969.

28. The family and the doctor: the general practitioner and the physical and mental health of the family. Proceedings of a conference held at Williamstown, Mass., January 21-23, 1964; sponsored by U. S. National Institute of Mental Health, Family Health Care Program, Harvard Medical School, and the Massachusetts Chapter, American Academy of General Practice, Harriet H. Gibney (Editor). Boston, 1965. 112 pp.

This conference report includes six papers on family medicine. In the first paper, "The Family Physician--Extinction or Rebirth?", E. M. Backett emphasized changing patterns of morbidity in family practice, i.e., the increasing importance of chronic and serious diseases and presymptomatic screening. He also advocated better use of new epidemiological knowledge of family vulnerability. The discussants were George Silver, M.D., and J. Wilson Brown, M.D. Dr. William Watson's paper, "The American Family and Medical Practice," traced sociological changes in the American family in detail in the last 70 years and pointed out that "the medical sciences will certainly be challenged to provide answers to the new familial problems and will be called on even more than in the past to play an active role in the whole area of familial relations." "The Family as a Unit of Illness" was presented by John Apley, M.D. He considered physical aspects of family illness, the pathology of the family, some genetic anomolies diagnosable clinically, metabolic disorders, carriers of family illness, infections, and practical matters in family doctoring, including psychosomatic, emotional and mental aspects of family practice. "Collaborative Research in General Practice," by John J. Haggerty, M.D., referred to collaboration between the practitioner and the university researcher. The author indicated his feeling that practitioners in Great Britain who were conducting such collaborative research "found this activity to be the spice of their life and...were better practitioners because of it." There is a brief summary of a paper by Roger J. Meyer, M.D., on the importance of the family in preventing childhood accidents. In his paper, "Family Psychiatry in Family Practice," John G. Howells, M.D., D.P.M.,

II. GENERAL REFERENCES FOR TRAINING PROGRAMS

28. The family and the doctor. AAGP, Boston, 1965 (Cont.)

discussed some concepts of the effect of the family in psychiatric illness and the role which the family physician may be able to play in the treatment of mental illness. There is a discussion by Peter H. Wolff, M.D.
112 footnote and chapter references.

29. Freidson, E. Patients' views of medical practice. New York, Russell Sage Foundation, 1961. 268 pp.

This book grew out of the author's experience as social science resident with the Family Health Maintenance Demonstration (see Silver, item 73). Data were obtained from: a series of three questionnaires mailed to husbands and wives of demonstration families; a questionnaire mailed to a random 10 per cent sample of Health Insurance Plan subscribers who were not working with the Demonstration Project; a series of intensive interviews with 71 subscribers and 36 families--53 were participating in the Demonstration Project and 18 were not. Chapter titles describe the content: Chapter 1, Three Types of Medical Practice in the Bronx; Chapter 2, Patient Attitudes toward Medical Care; Chapter 3, Patients' Attitude toward Medical Practice; Chapter 4, The Family Health Maintenance Demonstration; Chapter 5, Choices between Professions in the Health Programs; Chapter 6, Choices between Medical Practices; Chapter 7, Choices between Practices and the Lay Referral System; Chapter 8, The Role of the Organization of Practice; Chapter 9, Dilemmas in the Doctor-Patient Relationship; Chapter 10, The Structure of Doctor-Patient Relationships, and Chapter 11, Modern Medical Practice and the Fate of the Patient. 150 footnote references.

30. Glaser, William A. Paying the doctor: systems of remuneration and their effects. Baltimore, Johns Hopkins Press, 1970. 323 pp.

From May, 1961, through August, 1962, the author visited 16 countries and interviewed a large number of official and unofficial informants, and examined organizational files, publications, and institutional records. He has used this data to discuss in detail the social, political, and professional consequences of various systems of payment for physicians. In addition to the extensive referencing, this work is useful as a source book because its painstaking organization permits the reader to obtain information on as exact an area as his interest may focus upon. 707 footnote references.

II. GENERAL REFERENCES FOR TRAINING PROGRAMS

31. Haggerty, Robert J. The university and primary medical care. New Eng. J. Med., 281, 416-422, 1969.

32. Hodson, Mark. Doctors and patients: a relationship examined. London, Hodder & Stoughton, 1967. 159 pp.

33. Hogarth, James. The payment of the physician: some European comparisons. New York, MacMillan, 1963. 684 pp.

34. Holman, Holstead. The "antileadership vaccine" in medical education. Ann. Intern. Med., 68, 679-683, 1969.

35. Horder, John. Education after the Royal Commission. J. Roy. Coll. Gen. Pract., 18, 9-21, 1969.

36. Kendall, Patricia L. The relationship between medical education and medical practitioners: sources of strain and occasions for cooperation. Evanston, Ill., Association of American Medical Colleges, 1965. 122 pp.

This book describes a study undertaken at the request of the American Association of Medical Colleges to study the relationships between medical educators and medical practitioners. Seven communities with medical schools were chosen for the study. In each community the first person contacted was the dean of the medical school who, after an interview, was asked to provide the names of key practitioners in the community. Other strategic people in the medical school were also interviewed and the same request was made. All educators were able and willing to identify practicing physicians who were hostile to the medical schools as well as those who held friendlier attitudes.

One hundred twenty-five interviews were conducted each about an hour in length; 56 were medical educators and 69 were practitioners. The author identifies two major themes in her findings. The first was that individuals with opposed interests and viewpoints often assumed that they were in complete disagreement about a situation. Objective analysis revealed they agreed on the facts of a case and disagreed mainly on the evaluation of these facts. The second major trend had to do with displacement of one group by another. For example, a larger group of full-time staff meant the gradual displacement of part-time teachers; the trend toward specialization led to the displacement of the general practitioners. The greater prestige of research tended to displace the power of clinical faculty members, and younger faculty members tended to displace the older more traditionally-minded members. The four main headings of the report are:

II. GENERAL REFERENCES FOR TRAINING PROGRAMS

36. Kendall, Patricia L. Evanston, Ill., Association of American Medical Colleges, 1965 (Cont.)

A. Private Practice by Full-Time Faculty Members; B. The Displacement of Groups of Physicians; C. Medical Educators' Lack of Orientation to the Community, and D. The Growth of an Orientation to Research. 20 footnote references.

37. Lunn, V. Ways of educating medical students through the medium of psychiatry. In, Preparation of the Physician for General Practice. Public Health Paper No. 20, Geneva, World Health Organization, 1963. Pp. 67-84.

38. Lyden, F. J., Geiger, H. J. and Peterson, O. L. The training of good physicians: critical factors in career choices. Cambridge, Mass., Harvard University Press, 1968. 245 pp.

39. Magraw, R. M. Ferment in medicine: a study of the essence of medical practice and its new dilemmas. Philadelphia and London, W. B. Saunders Co., 1966. 272 pp.

40. Magraw, R. M. Language of medical care. New Eng. J. Med., 279, 383-384, 1968.

41. Main, T. F. The ailment. Brit. J. Med. Psychol., 30, 129-145, 1957.

In this article, the author describes his work with a small group of nurses. Over a period of years they worked to understand certain particularly difficult patients. The depth and complexity of the feelings involved were surprising, and the discovery and increasing understanding of these feelings is explained in the article in such a way that there emerges a great deal of material crucially relevant to the healing professions, especially physicians and nurses. The role and importance which feelings can have for improved patient care and the intricacy of group phenomena within and between staff and patients in any hospital setting are also explored. 9 references.

42. Mechanic, David. The sociology of medicine: viewpoints and perspectives. J. Health Human Behav., 7, 237-248, 1966.

II. GENERAL REFERENCES FOR TRAINING PROGRAMS

43. Morgan, William L., Jr. and Engel, George L. The clinical approach to the patient. Philadelphia, London and Toronto, W. B. Saunders Co., 1969. 314 pp.

According to the authors, this book is "designed to guide the beginning student in the steps used to acquire, analyze and report clinical data derived from the patient." The authors' approach represents a sophisticated blend of the humanitarian and scientific, and this is unique enough to command the attention of all physicians or teachers of physicians. As an example, the authors point out that a general consideration of the roles of the physician and the patient does not define the nature of the relationship between any one physician and patient. Rather, this is "determined more by the circumstances of the illness, the personal characteristics of the physician and of the patient, and the previous experiences of each. By no means are all of these either conscious or rational on the part of either." The diagnostic process is described as "one of the greatest challenges of medicine. It tests the physician's power of logic and reasoning, and should be as scientific as isolating an enzyme in a laboratory." The discussion of interviewing includes techniques to be used with a number of different types of patients: acutely ill; seriously ill; delirious or demented; psychotic; depressed; mentally defective; disphasic, and heard of hearing. 43 footnote and chapter references (approx.).

44. Querido, A. The efficiency of medical care: a critical discussion of measuring procedures. Leiden, Stenfert & Kroese, 1963. 288 pp.

This book by a Dutch physician describes the evaluation of medical care as it relates to the fields of prevention, hospital care, mental health, geriatrics, chronic illness, and the handicapped. Part 2, Chapter 1, deals with the family physician and a number of research studies are described. Included are a questionnaire study of 270 of the 331 family physicians registered in Amsterdam in 1951, and the results of interview records of some 2,000 families covering 6,796 people. These interviews were conducted to investigate the adequacy of health care. Also discussed is a study in which five general practitioners participated. It involved three sections: (1) The doctors were observed for periods ranging from one year to three months in order to make an analysis of their daily work. (2) From each of the five practices a 5 per cent sample of patient families was obtained, yielding 125 families (401 persons). A physician went to visit the families and gave each member a medical examination including lab work. (3) At the time of the examination, discussions about psychological and social problems

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44. Querido, A. Leiden, Stenfert & Kroese, 1963 (Cont.)

were begun and these were continued at a later date. The results cover virtually every aspect of evaluating the work of the family physician, but it is interesting to note that of the 401 persons who were examined, only three had a serious disorder of which the general practitioner was unaware. 141 footnote references.

45. Richards, D. H. Dilution in general practice. Lancet, 1, 41-42, 1966.

46. Richmond, Julius B. Currents in American medicine: a developmental view of medical care and education. Cambridge, Mass., Harvard University Press, 1969. 138 pp.

47. Sanazaro, P. J. and Williamson, J. W. A classification of physician performance in internal medicine. Proceedings of the Sixth Annual Conference on Research in Medical Education. J. Med. Educ., 43, 389-397, 1968. (For annotation, see item 87.)

48. Shapiro, S. End result measurements of quality of medical care. Milbank Mem. Fund Quart., 45, No. 2, Part 1, 7-30, 1967.

49. Sidel, V. W. Evaluation of the quality of medical practice. JAMA, 198, 763-764, 1966.

50. Silver, G. A. Some considerations of medicine as a social instrument: toward a more dynamic policy of medical education. Med. Care, 1, 44-46, 1963.

51. Stoeckle, J. D., Zola, I. K. and Davidson, G. E. On going to see the doctor. J. Chronic Dis., 16, 975-989, 1963.

52. Symposium on the quality of medical care, 1965. J. Coll. Gen. Pract., 11, Suppl. 3, 1-36, 1966.

53. White, Kerr L. Medical care research and health services systems. J. Med. Educ., 42, 729-741, 1967.

54. Williams, Tennyson (Editor). Education for family practice. Proceedings of a seminar held at Columbus, Ohio, April 24-25, 1968. Copies available from Ohio Academy of General Practice, 4075 North High Street, Columbus, Ohio, 43214. 74 pp.

55. Yellowlees, W. W. The primary physician: generalist or specialist? Proc. Roy. Soc. Med., 62, 739-741, 1969.

II. GENERAL REFERENCES FOR TRAINING PROGRAMS

56. Zabarenko, R. N., Zabarenko, Lucy and Pittenger, R. A. The psychodynamics of physicianhood. Psychiatry, 33, 102-118, 1970.

III. RESEARCH IN FAMILY PRACTICE

The voluminous research in family practice has been subdivided for easier access. In those cases where the research reports listed in this section may have value in residency training, these references have been designated by an asterisk.

A. General Research References

This group of references includes general accounts of research, reports of organizations responsible for coordinating research efforts, for example, Rowe (1968), and some historical material such as that of Chand (1969) and Plowright (1963).

57. Australian College of General Practitioners. Research Digest, 1, 1958-1968. Ian L. Rowe (Editor). 112 pp.

    This review presents a good picture of the scope and amount of research in general practice being done in Australia, and the energetic way in which the Australian College of General Practitioners has monitored and disseminated the results of this research. Among the studies reported are those involving: morbidity; community usage; respiratory diseases; drugs; hormones; anesthetics; obstetrical problems; research in general practice, and research in medical education. One hundred two research projects either completed or in progress are listed. There is a bibliography of 84 research articles published by members of the Australian College of General Practitioners.

58. British Medical Association. The new general practice. London, Brit. Med. Assoc., 1968.

59. Chand, Anier. Research in general practice and its contribution to the advancement of medical knowledge. Indian J. Med. Res., 57, 605-616, 1969.

60. Council of the Royal College of General Practitioners. Report: the research advisory service 1963-1967. J. Roy. Coll. Gen. Pract., 17, 119-124, 1969.

61. Fraser, Robin C. Research methods in general practice: a report on a course at the College. J. Roy. Coll. Gen. Pract., 17, 385-387, 1970.

62. Hinckle, L. F. and Wolff, H. G. Health and the social environment: experimental investigations. In, Explorations in Social Psychiatry, A. H. Leighton, J. A. Clausen and R. N. Wilson (Editors). New York, Basic Books, Inc., 1957. Pp. 105-137.

III. RESEARCH IN FAMILY PRACTICE

A. General Research References (Cont.)

63. Last, J. M. The measurement of medical care and general practice. Med. J. Aust., 1, 280-283, 1965.

*64. Lees, D. S. and Cooper, M. H. The work of the general practitioner: an analytical survey of studies of general practice. J. Coll. Gen. Pract., 6, 408-434, 1963.

This article is a critical review of 37 major studies of general practice, including two from America. In the first section, the authors discuss problems in methodology and interpretation arising from different uses and definitions of crucial concepts such as: population at risk, consultation rates, episodes of illness and diagnostic classification. In the second section results are compared. There are tables showing wide variations on certain variables, for example, from 12.0 per cent to 68.2 per cent of total consultations in home visits, and striking similarities in other variables--female consulting rates are uniformly higher than those for males. Data are presented also on workload, rural, semi-urban and urban practices, age and sex distributions in patient populations, and diagnostic groupings. 14 tables. 37 references.

*65. Ley, P. and Spelman, M. S. Communicating with the patient. Worcester and London, Ebenezer Baylis & Son Ltd., 1967. 128 pp.

This book deals mainly with the problems of communication with hospital patients, and the authors include data from their own research and that of others. These points include, for example, the fact that adequately informing the patient is one way for the staff to show that they recognize "that the patient, although temporarily physically abnormal, is normal mentally--in other words, is still a human being." There is a table containing data from 19 studies whose results indicate that when patients fail to cooperate--to take medicine, adhere to diets--they have frequently received insufficient information to be able to follow instructions and advice properly. In addition, the authors present evidence that intelligence is not related crucially to the ability to remember medical information, nor is age; anxiety level and general knowledge of medical matters are related to memory of medical information. Chapter titles are: (1) Staff-Patient Communications in Hospitals; (2) Suggested Methods of Improving Communications; (3) The Effectiveness of the Suggested Remedies for Communications; (4) Do Patients Follow the Advice Given by Doctors; (5) Comprehension and Communication; (6) Memory Aspects of Communications; (7) Persuading Patients to Follow Advice; and (8) Summary and Conclusions. 82 references.

III. RESEARCH IN FAMILY PRACTICE

A. General Research References (Cont.)

66. Mawardi, Betty H. Relation of student learning to physician performance. JAMA, 198, 767-769, 1966.

67. Noble, H. M. S. What the general practitioner sees: a comparison of cases seen in a Canadian and a Scottish practice. J. Coll. Gen. Pract., 8, 60-65, 1964.

68. Paterson, P. M. M. O. and Bone, Sylvia. Diagnostic problems in general practice. J. Roy. Coll. Gen. Pract., 16, 451-461, 1968.

69. Plowright, O. General practice in England: an historical note. J. Coll. Gen. Pract., 6, 532-545, 1963.

70. Research Unit of the Royal College of General Practitioners, Great Britain, and the Newfoundland Chapter of the College of Family Physicians of Canada. A transatlantic morbidity study. J. Roy. Coll. Gen. Pract., 18, 137-147, 1969.

71. Sanazaro, Paul J. An agenda for research in medical education. JAMA, 197, 979-984, 1966.

*72. Shields, P. J. "The best is yet to be." An evaluation and comparison of general-practitioner medical services. Brit. Med. J., 1, Part 1, 49-52, 1965.

*73. Silver, G. A. Family medical care: a report on the Family Health Maintenance Demonstration. Cambridge, Mass., Harvard University Press, 1963. 359 pp.

This book reports an eight-year study involving the Family Health Maintenance Demonstration Project whose objectives, in addition to providing medical care, were to motivate families to maintain good health, to observe the families carefully, and to evaluate the results of the study. One hundred twenty-four families were randomly selected for the demonstration project from the rolls of the Health Insurance Plan of New York, and 110 matched controls were also studied. Extensive records were kept on medical, psychological, and social aspects of the families as well as the activities of the team, and these are reported in detail. 65 tables. 285 references.

74. Symposium on Society and its General Practitioners, 1967. J. Roy. Coll. Gen. Pract., 17, Suppl. 1, 1-37, 1969.

75. Walford, P. A. The practice index. J. Coll. Gen. Pract., 6, 225-232, 1963.

III. RESEARCH IN FAMILY PRACTICE

A. General Research References (Cont.)

76. Weinerman, E. R. Research into the organization of medical practice. Milbank Mem. Fund. Quart., 44, 104-145, 1966.

*77. Zola, I. K. Culture and symptoms--an analysis of patients' presenting complaints. Amer. Sociol. Rev., 31, 615-630, 1966.

This article begins with a discussion of some of the concepts which medical sociology can add to medical practice, and these may be of special interest to family physicians. Differing delimitations of the concept of illness as these exist in the individual, in ethnic groups, in doctors, and in medical institutions are considered. Dr. Zola also describes his study comparing 39 female and 29 male Italian and 42 female and 39 male Irish patients, presenting for their first visit to three Boston clinics. The ability and manner in which physical symptoms and accompanying feelings were described and the ways of viewing illness in general were strikingly different in these groups. 113 footnote references.

III. RESEARCH IN FAMILY PRACTICE

B. Methodology

For the investigator, either beginning or experienced, research in family practice presents unusually difficult problems in methodology. The references cited below suggest some general concepts, such as those of Draper (1969) and Froggatt, et al (1969), and give examples of imaginative approaches to these problems--see Kroeger, et al (1965).

*78. Abrams, M. E., Bowden, K. F. and Chamberlain, Jocelyn. A computer-based general practice and health centre information system. J. Roy. Coll. Gen. Pract., 16, 415-427, 1968.

79. Clarke, A. H., Dixon, R. A. and Rickards, D. F. "Practis." (General) practice recording and computer terminal information system. J. Roy. Coll. Gen. Pract., 17, 60-63, 1969.

80. Draper, G. J. Methods of sampling patients in studies of general practice. J. Roy. Coll. Gen. Pract., 15, 208-215, 1968.

81. Eimerl, Teviot S. and Laidlaw, A. J. (Editors). A handbook for research in general practice. Edinburgh and London, E. & S. Livingstone Ltd., 1969. (2nd Edition) 115 pp.

This book contains descriptions of research projects from many contributors. Precise accounts of how the research was conducted are included, as well as specific instruments, such as the E Book, F Book, W Book, and S or summary cards. Long-term projects in progress are covered, and the coordinating role of the College of General Practice Research Council is described. Chapter headings are: (1) A Logical Approach; (2) College Research, Research on Committee Council (Royal College of General Practitioners); (3) Planning Group Research; (4) Proven Research Methods; (5) Using a Medical Library; (6) Writing for Publication; (7) Financing Research; (8) Colleges Overseas, and (9) Modern Data Processing and its Relationship to General Practice. Within the book there is a list of 25 projects completed and published by members of the Australian College of General Practitioners and a list of eight research publications of the Canadian College of Family Practice. The bibliography used for the book has 11 items. There is an additional list of 115 research works published by members of the Royal College of General Practitioners of Great Britain.

82. Froggatt, P., Dudgeon, M. Y. and Merrett, J. D. Consultations in general practice: analysis of individual frequencies. Brit. J. Prev. Soc. Med., 23, 1-11, 1969.

III. RESEARCH IN FAMILY PRACTICE

B. Methodology (Cont.)

*83. Hodes, Charles. The structure and function of a file of patient health data in general practice. J. Roy. Coll. Gen. Pract., 15, 286-291, 1968.

84. Kramer, Morton. Epidemiology, biostatistics, and mental health planning. In, Psychiatric Epidemiology and Mental Health Planning, R. R. Monroe, G. D. Klee and E. B. Brody (Editors). American Psychiatric Association, Psychiatric Research Report 22, 1967. Pp. 1-63.

85. Kroeger, H., Altman, I., Clark, D. A., Johnson, A. C. and Sheps, C. G. The office practice of internists. JAMA, 193, 371-376, 1965.

86. Remington, Richard. How many experimental subjects? or one good question deserves another. Circulation, 39, 431-434, 1969.

87. Sanazaro, P. J. and Williamson, J. W. A classification of physician performance in internal medicine. Proceedings of the Sixth Annual Conference on Research in Medical Education. J. Med. Educ., 43, 389-397, 1968.

In this study the critical incident technique was used to establish a classification of physician performance. 2,499 physician faculty members from 20 medical schools in 14 states were asked to write six detailed performance descriptions (critical incidents)--three effective and three ineffective. Of the resulting 12,886 incidents, 2,589 were descriptions of internists, and these are the subject of analysis in this paper. Half of the incidents were self-reports. Tables show the relationship of the frequencies of effective and ineffective action to the reported outcomes of medical care. The authors feel their results suggest that one reason faculty members often neglect teaching students how to behave with patients is that they themselves could benefit from similar instruction. 25 references.

III. RESEARCH IN FAMILY PRACTICE

C. Single Practice Studies

One might assume that the solo practitioner would be the least likely to have the time and energy to add research to the burdens of his workload. The studies in this section demonstrate that, in fact, this is not so. Some of the most thoughtful research in the field has come from curious and devoted doctors using data in their own practices.

88. Baker, C. D. A practice pattern of patient-doctor contact. J. Coll. Gen. Pract., 12, 54-67, 1966.

89. Bebbington, Robert. A review of 508 consecutive patients seen in general practice. J. Roy. Coll. Gen. Pract., 18, 27-37, 1969.

*90. Freeling, P. The significance of symptoms. Proc. Roy. Soc. Med., 60, 972-975, 1967.

General practitioners have been criticized because their screening of patients is based upon a "probabilistic" approach, that is, the choice of a diagnostic procedure is based on a clinical judgment arrived at by using the doctor's experience from his practice as it interacts with his experience with a particular patient. Dr. Freeling decided to test the validity of this criticism by recording how often his decisions in the case of vaginal examinations were confirmed. The decision to perform a bimanual examination was validated at 38 per cent; speculum examination was validated at 57 per cent. The author points out that if ancillary medical personnel are to begin to perform some of the doctor's screening functions, further research to check upon the accuracy and validity of this screening approach will be needed. 7 references.

91. Fry, J. Planning for general practice. Practitioner, 197, 143-151, 1966.

*92. Greco, R. and Pittenger, R. One man's practice. New York, Lippincott and Co., 1966. 117 pp.

In this book a general practitioner and a psychiatrist colleague trace with painstaking documentation the character of a general practice, and the changes which took place in it after three and a half years of the doctor's participation in courses in psychotherapeutic medicine. Examination of the practice continued during the four years the book was written. There are vivid descriptions of all aspects of the work, including the 20 to 25 per cent of the practice devoted to primary, secondary, and tertiary preventive medicine, and the development of increasingly more useful and focused doctor-patient transactions. 6 references.

III. RESEARCH IN FAMILY PRACTICE

C. Single Practice Studies (Cont.)

93. Hull, F. M. Social class consultation patterns in rural general practice. J. Roy. Coll. Gen. Pract., 18, 65-71, 1969.

94. Jacob, Albert. An "artificial practice" as a tool for research into general practice. J. Coll. Gen. Pract., 11, 41-48, 1966.

*95. Krass, I. M. Is there abuse in general practice? Discussion of the workload of general practitioners. J. Coll. Gen. Pract., 10, 124-132, 1965.

*96. McGregor, R. M. The work of a family doctor. Edinburgh and London, E. & S. Livingstone Ltd., 1969.

97. Payne, E. M. Margaret. The number of items of general medical service provided by a general practitioner in one year (1964). J. Coll. Gen. Pract., 12, 172-183, 1966.

98. Pinsent, R. J. Continuing care in general practice. J. Roy. Coll. Gen. Pract., 17, 223-226, 1969.

99. Sadler, Paul. The primary physician: generalist or specialist. Proc. Roy. Soc. Med., 62, 741-743, 1969.

100. Spenser, J. T. A diagnostic work-study index: a use of the E Book to measure workload in relation to morbidity. J. Coll. Gen. Pract., 13, 39-54, 1967.

101. Van Deen, K. J. Primary medical care. 2. Analysis of the workload. Milbank Mem. Fund Quart., 43, 277-284, 1965.

102. Waterston, J. F. C. Morbidity in a country practice. J. Coll. Gen. Pract., 10, 18-39, 1965.

III. RESEARCH IN FAMILY PRACTICE

D. Research by Small Groups

Where a small group of physicians, from two to ten, have worked together, the increased specificity and scope of studies reveal the benefits of the combined effort.

*103. Bird, Angus and Colling, Aubrey. Family interviews in general practice. J. Roy. Coll. Gen. Pract., 15, 123-127, 1968.

Struck by the fact that families often have problems of which the doctor is unaware, two physicians in partnership set out to interview a sample of 100 families in their care. Nineteen families came for interviews, the remainder were sent questionnaires. The authors developed an interviewing technique, talked with the families for an average of 40 minutes, spoke mostly with adult members (though the children were frequently present) and did not have an opportunity to do a physical examination prior to the interview. They report that the interviewed families began to think about health in a different way, and the doctors learned a great deal about the families. Inadequate follow-up of medical problems and gaps in immunization, for example, were a common finding. In the following year there were fewer consultations in both the interviewed and non-interviewed groups. 4 references.

104. Crombie, D. L. and Cross, K. W. The workload in general practice. Lancet, 2, 354-356, 1964.

*105. Evans, S. M., Wilkes, E. and Dalrymple-Smith, D. Presymptomatic diagnosis: a study in a country practice. J. Roy. Coll. Gen. Pract., 17, 237-246, 1969.

*106. McCoy, Yvette. An experiment in community medicine in general practice. Practitioner, 200, 292-295, 1968.

107. Marinker, M. Studies of contact behaviour in a general practice: an exposition of methods and a consideration of meanings. J. Roy. Coll. Gen. Pract., 14, 59-66, 1967.

*108. Marinker, M. The general practitioner as a family doctor. J. Roy. Coll. Gen. Pract., 17, 227-236, 1969.

This article reports a study of family illness over a one-year period in a two-physician practice. For 2,015 individuals, family relationships and structures were studied, especially as these related to health. The author suggests

III. RESEARCH IN FAMILY PRACTICE

D. Research by Small Groups (Cont.)

*108. Marinker, M. J. Roy. Coll. Gen. Pract., 17, 227-236, 1969 (Cont.)

that studies of the patterns of family morbidity are rare because "we do not yet know the spatial or temporal framework in which we must make our measurements." Via some case histories, he presents data suggesting the possibility of "traditions of family illness" and points out the usefulness of discovering these patterns to the family physician. 9 references.

109. Wolfe, S., Badgley, R. F., Kasius, R. V., Garson, J. Z. and Gold, R. J. M. The work of a group of doctors in Saskatchewan. Milbank Mem. Fund Quart., 46, 103-129, 1968.

III. RESEARCH IN FAMILY PRACTICE

E. Large-Scale Studies

Surveys including large numbers of physicians and instances are possible where adequate funding, staff and time are available. Many of these projects originated in medical schools, some have been sponsored by practitioners, for example, Clute (1964). All are impressive for the persistence and hard work evidenced by the investigators as they attempted to learn more about the complex entity of family practice.

110. Andersen, N. A. An assessment of the structure of general practice in New South Wales: report of a survey. Med. J. Aust., 2, Suppl. 12, 155-166, 1968.

111. Baker, A. S., Parrish, H. M. and Bishop, F. M. What do rural general practitioners in Missouri really do in their offices? Missouri Med., 64, 213-217, 1967.

Twenty-five general practitioners serving in the Department of Community Mental Health and Medical Practice, University of Missouri School of Medicine, were observed by third and fourth year medical students during a four-week preceptorship in the practitioners' offices. After having spent seven to fourteen days with the preceptor and having adequately pre-tested the record forms, student observers filled out two forms: a daily log and a patient evaluation form. Office work was classified into seven activities: personal, administrative, preventive, health information and counseling, diagnosis and treatment, and other. Definitions of each of these activities are given, as are data indicating the amount of time spent engaged in each. There is also more general information about the practice, e.g., the age and training of the doctors, the age, sex, race, and total number of patients. The authors were struck by the amount of time spent in giving health information and counseling and in business and personnel management, and felt that more time should be given to training in these areas in medical school. 5 references.

*112. Clute, K. F. The general practitioner: a study of medical education and practice in Ontario and Nova Scotia. Toronto, University of Toronto Press, 1963. 566 pp.

A sample of 85 general practitioners in two Canadian provinces were selected for this study on the basis of the consistency in certain variables: all were graduates of Canadian medical schools,

III. RESEARCH IN FAMILY PRACTICE

E. Large-Scale Studies (Cont.)

*112. Clute, K. F. Toronto, University of Toronto Press, 1963 (Cont.)

under 60 years of age, and male. The sample was stratified to include a range of ages in the doctors and a range of size of community in which the practice was located.

The doctors were observed in their practices for three days by a trained physician. The practitioners completed a questionnaire and provided a list of patients for seven days including the three observation days. The instrument used for evaluation of medical performance was a cumulative point scale with a total of 80, a modified form of the Peterson Scale (see item 121). In addition to performance, data were reported on the background and education of the physician, his career, his practice in the office and outside of it, his organization of his time, his relations with hospitals, the medical profession and pharmaceutical industry, financial aspects of the practice, and certain aspects of personal life. Much of the results are presented in tabular form, but there is also ample description of the doctors' work and their lives. 104 tables. 135 footnote references.

113. Densen, P., Greene, D., Moskowitz, R., Sack, J., Scheff, D., Taw, R., Trump, D., Zawatzky, L. and Starfield, Barbara. Primary medical care for an urban population: a survey of present and potential utilization. J. Med. Educ., 43, 1244-1249, 1968.

114. Eimerl, Teviot S. Patterns of consultation. J. Coll. Gen. Pract., 10, 133-140, 1965.

Over an 11-year period, patterns of consultation in doctors' offices were studied, and this article reports results for 65,890 attendances, with the focus on parent-child visits. Quarterly consulting rates are given and the authors note that over the 11 years, one of every six to seven consultations (16.1 per cent) of the total were maternal consultations. Annual patterns of consulting were also noted, e.g., March was the highest month for maternal consultations; September was second. The author suggests that there should be more accurate recording of the nature of parental visits, for example, those occasions when adults come to the doctor because they are concerned primarily with the health of the child as contrasted with visits scheduled explicitly for the child. Better recording

III. RESEARCH IN FAMILY PRACTICE

E. Large-Scale Studies (Cont.)

114. Eimerl, Teviot S. J. Coll. Gen. Pract., 10, 133-140, 1965 (Cont.)

will increase the precision of studies in general practice and will aid the doctor in special planning for and handling of these doctor-parent-child transactions. 3 references.

*115. Eimerl, Teviot S. Working-time in general practice: how general practitioners use their time. Brit. Med. J., 2, 1549-1554, 1966.

116. Huntley, R. R. Epidemiology of family practice. JAMA, 185, 175-178, 1965.

*117. Joyce, C. R. B. What does the doctor let the patient tell him? J. Psychosom. Res., 8, 343-352, 1964.

118. Last, J. M. Quality of general practice. Med. J. Aust., 1, 780-784, 1967.

The author interviewed 94 Australian general practitioners on a number of aspects of their work. He used data from this work and from his survey of previous research in this consideration of evaluation problems. Peterson's observational methods (see item 121) were criticized for the use of teaching hospital standards in judging office general practice and because of the difficulties in assessing the effects of the observer on the observed. The professional isolation of the general practitioner (perhaps of special interest in Australia) was felt to be a part of his "emotional makeup." The benefits of continuity of care and primary medical responsibility were critically examined. More contact with medical school faculty and the attachment of medical students to general practices are strongly suggested as an incentive for improving the quality of care. 45 references.

119. Lough, J. D. The content of general practice: a survey of 42 practices. New Zeal. Med. J., 66, 23-27, 1967.

120. Mathewson, Herbert O. Two experimental general practices. Arch. Environ. Health, 14, 809-820, 1967.

*121. Peterson, O. L., Andrews, L. P., Spain, R. S. and Greenburg, B. G. An analytical study of North Carolina general practice 1953-54. J. Med. Educ., 31, No. 12, Part 2, 1956.

The 88 North Carolina general practitioners who were studied in this research were selected from a total state population of

III. RESEARCH IN FAMILY PRACTICE

E. Large-Scale Studies (Cont.)

*121. Peterson, O. L., et al. J. Med. Educ., 31, No. 12, Part 2, 1956 (Cont.)

general practitioners so as to constitute a representative stratified sample, drawn by a random procedure. The observers, internists from the faculty of the University of North Carolina Medical School, spent an average of three and one-half days observing each practice. During this time they completed a questionnaire, obtained additional information and made evaluations of the doctors' performance. Fourteen practices were observed by two internists as an inter-observer check. The results are displayed in 44 tables and the record forms appear in the five appendices. The instrument used for the evaluation of performance was a detailed, cumulative point scale, reflecting the importance of adequate investigation and diagnosis. In addition to the chapters on the research techniques and their rationale, there are reports of the education and training of the doctor, his medical intellectual life, the doctor and the medical community, the doctor's workshop (the physical plant), the doctor's family and community background, non-medical activities, doctor's hours and wages, and patients and their disease. 44 tables. 64 footnote references.

122. Riley, Gregory J., Wille, Carl R. and Haggerty, Robert J. A study of family medicine in upstate New York. JAMA, 208, 2307-2314, 1969.

The practices of 51 urban and 52 rural physicians in the Rochester (New York) Regional Hospital Council area were studied by means of focused interviews and direct observation of one complete professional day. Among the variables reported are the age, training, workload and educational interests of the physician, and age, race and sex of patients during the day observed. The authors (two of whom were medical students at the time the study was conducted) used four categories to categorize the doctors' activities: (1) preventive measures were employed with 9.9 per cent of the patients; (2) in 21 per cent of the visits, preclinical illness was investigated; (3) diseases were treated in 66.5 per cent of the visits, and (4) rehabilitation was undertaken in 25 per cent of contacts. The categories were not mutually exclusive. Also reported are the percentage of doctor-patient contacts in which there was acute illness, chronic illness or no illness, and the frequency of diagnostic procedures, direct therapeutic action, prescription, therapeutic talking and listening, and referral rates. 17 references.

III. RESEARCH IN FAMILY PRACTICE

E. Large-Scale Studies (Cont.)

123. Royal College of General Practitioners. General practice in South-West England: report of a survey of 68 practices in the South-West England Faculty of the Royal College of General Practitioners 1964-65. H. J. Wright, recorder. J. Roy. Coll. Pract., 15, Reports from General Practice VIII, 1-41, Jan., 1968.

This study was based on four sets of records completed by each of the 68 participating practitioners. These were: thirty questions relating to personal and practice matters; specified items of weekly work recorded for four specified weeks in each quarter of the year; specified details of every consultation recorded for four specified weeks in every quarter, and specified details for every consultation for one week in each quarter. Consultation rates were analyzed by: (1) season; (2) practice location (rural, urban or mixed); (3) practice character (single, group, and number of doctors in a group); (4) number of patients in the practice; (5) whether or not there was dispensing in the practice; (6) the presence or absence of home visitors and nursing help; (7) use of an appointment system; (8) patient age; (9) postgraduate training of the practitioner, and (10) his access to hospital beds. Home visits, indirect consultation rates, prescription rates, and patterns of practice--patients attending morning, afternoon and evening--were analyzed in similar detail. 19 tables. 46 references.

124. Scotton, R. B. and Grounds, A. D. Survey of general practice in Victoria. Med. J. Aust., 1, Suppl. 1, 1-8, 1969.

The Victorian Branch of the Australian Medical Association sponsored a questionnaire survey in which 90 metropolitan and 86 country doctors responded. Comparisons of workload and income are reported. There was no significant difference between the two groups for the total work hours per week (the median was 56), and the amount of time per consultation was also similar--15.2 minutes for office, and 22.4 minutes for home visits. Income and financial data are recorded for the year ending June 30, 1967. The median income for metropolitan doctors was $11,230, and $12,440 for country doctors. Physicians working in groups earned more than those in solo practice. A greater proportion of the income of rural practitioners came from operations, confinements and anesthetic work than in the practices of metropolitan physicians. 21 references.

III. RESEARCH IN FAMILY PRACTICE

E. Large-Scale Studies (Cont.)

125. Sellers, E. M. The influences of group and independent general practice on patient care: a comparative study in Ontario. Canad. Med. Ass. J., 93, 147-157, 1965.

126. Sheps, C. G., Sloss, J. H. and Cahill, E. Medical care in Aluminum City - I. Families and their regular doctors. J. Chronic Dis., 17, 815-826, 1964.

A household survey was conducted in a small industrial community in Western Pennsylvania to obtain baseline data on the use of and attitudes toward medical care services. A representative sample of about 33,000 was taken so as to include families in an adequate range of demographic and socio-economic groupings. Five hundred seventy-five family units (1,605 individuals) were interviewed in 504 households. Nearly 41 per cent of the family units reported an annual income of less than $4,000. Eighty-nine per cent of the family units were found to have one or more members with a "regular doctor" they usually saw. The most important factor in determining whether units had a family doctor was whether or not there were children in the unit. Income affected the existence of a relationship with a family doctor only among married couples without children. In almost 90 per cent of the units with regular doctors, one or more members had received medical services from the doctor during the two years prior to the interview. 12 references.

127. Taylor, C. W., Price, P. B., Richards, J. M. and Jacobsen, T. L. An investigation of the criterion problem for a group of medical general practitioners. J. Appl. Psychol., 49, 399-406, 1965.

III. RESEARCH IN FAMILY PRACTICE

F. Research on Specific Problems in Family Practice

As a body of general information about family practice became available, researchers began to turn their attention to specific problems. Among the phenomena studied have been: the repeat prescription patient, Balint (1970); compliance with doctors' orders, Davis (1966); the demand for urgent treatment in general practice, Forbes (1967); screening in general practice, Freeling (1969); morbidity, Kalton (1968); night calls, McDonald (1969), and Pridan (1969); adolescence, Model (1968); chronic high users, Semmence (1969) and Wamoscher (1966).

*128. Baker, C. D. A fifteen-year pattern of patient-doctor contact among "static" general practice patients. Brit. Med. J., 2, 106-107, 1966.

*129. Balint, Michael. Repeat prescription patients: are they an identifiable group? Psychiatry in Medicine, 1, 3-14, 1970.

130. Burnap, D. W. and Golden, J. S. Sexual problems in medical practice. J. Med. Educ., 42, 673-680, 1967.

*131. Clyne, M. Night calls. London, Tavistock Publications, 1963. 216 pp. (For annotation, see item 14.)

*132. Colling, A. The sick family. J. Roy. Coll. Gen. Pract., 14, 181-196, 1967.

One hundred sick families were studied beginning in 1958. There was no special interview, but all known information about the family was recorded and data were added and gaps filled in as family members came for consultations. Some family records spanned as long a time as 20 years. From his frankly "subjective and descriptive" point of view, the author provides three lists of important variables. Those factors which appeared to have a great effect in causing family sickness were: anxiety states in one or more members; depressive illness in one or more members; a husband economically dependent on the wife; marital disharmony; an alcoholic family member; a handicapped child; a schizophrenic family member, and a group of troubled families whose problems could not be more precisely described. Two variables which appeared to have some effect in causing family sickness were the presence of five or more children in the family and the presence

III. RESEARCH IN FAMILY PRACTICE

F. Research on Specific Problems in Family Practice (Cont.)

*132. Colling, A. J. Roy. Coll. Gen. Pract., 14, 181-186, 1967 (Cont.)

of a homosexual father or husband. There were four factors which appeared to have no effect in causing family sickness: the absence of children, adopted children, old people living on their own, and chronic illness in one or more members including psychiatric illness. 2 references.

133. Davis, M. S. Variations in patients' compliance with doctors' orders: analysis of congruence berween survey response and results of empirical investigations. J. Med. Educ., 41, 1037-1048, 1966.

134. Forbes, J. A., Mutch, L. M. M., Smith, G. T. and Tulloch, A. J. Study of the demand for urgent treatment in general practice. Brit. Med. J., 3, 856-858, 1967.

135. Freeling, P. Discussion on screening techniques in general practice. Practitioner, 202, 703-704, 1969.

136. Joyce, C. R. B., Last, J. M. and Weatherall, M. Personal factors as a cause of differences in prescribing by general practitioners. Brit. J. Prev. Soc. Med., 22, 170-177, 1968.

137. Kalton, G. The contribution of research in general practice to the study of morbidity. J. Roy. Coll. Gen. Pract., 15, 81-95, 1968.

138. Lloyd, Gareth. Practice organization and an influenza epidemic. Practitioner, 202, 424-427, 1969.

139. McDonald, I. R. Night telephone calls to a solo practitioner. Med. J. Aust., 1, Suppl. 3, 25-26, 1969.

140. Model, A. A family doctor's work with adolescent patients. Proc. Roy. Soc. Med., 61, 507-510, 1968.

141. Pridan, D., Navid, Helen and Epstein, Leon. A study of night calls in Jerusalem. J. Roy. Coll. Gen. Pract., 18, 272-280, 1969.

*142. Richman, G. Late call emergency or anxiety. J. Coll. Gen. Pract., 9, 241-245, 1965.

143. Scott, R. and Robertson, P. D. Multiple screening in general practice. Brit. Med. J., 2, 643-647, 1968.

III. RESEARCH IN FAMILY PRACTICE

F. Research on Specific Problems in Family Practice (Cont.)

*144. Semmence, Adrian. Chronic high users in a general practice. J. Roy. Coll. Gen. Pract., 17, 304-310, 1969.

145. Wamoscher, G. The returning patient: a survey of patients with high attendance rate. J. Coll. Gen. Pract., 11, 166-173, 1966.

IV. TRAINING IN FAMILY MEDICINE

A. General Reports

To meet the urgent need for education in comprehensive medical care, responses came in the form of special training programs in particular medical schools and efforts by organized groups within medicine. In the references below, where a specific program is described, its sponsoring body appears in parenthesis at the end of the listing.

146. Alpert, Joel J. Continuing education for family practice. Postgrad. Med., 45, 237-239, 1969. (Harvard Medical School)

147. American Association of Medical Colleges. Committee on Medical Schools and the AAMC in Relation to Training for Family Practice Report. Planning for comprehensive and continuing care of patients through education. J. Med. Educ., 43, 751-759, 1968.

148. American Medical Association. Committee on Education for Family Practice of the Council on Medical Education. Meeting the challenge of family practice. Chicago, AMA, Sept., 1966. 57 pp.

149. Balint, Enid. The possibilities of patient-centered medicine. J. Roy. Coll. Gen. Pract., 17, 269-276, 1969.

150. Beloff, Jerome S., Snoke, Parnie S. and Weinerman, E. Richard. Yale studies in family health care. II. Organization of a comprehensive family health care program. JAMA, 204, 355-360, 1968. (Yale University and Yale-New Haven Hospital, New Haven, Conn.)

151. Byrne, P. S. Preparation for teaching in general practice. J. Roy. Coll. Gen. Pract., 17, 69-79, 1969.

152. Caliva, Francis S., Mullin, Edward W., Gigantelli, Thomas N., Needham, Charles N., McLean, Roderick A. and Notkin, Herbert. An experiment in education for family practice. JAMA, 195, 101-104, 1966. (St. Joseph's Hospital, Upstate Medical Center, State University of New York)

153. Carmichael, Lynn P. A program of instruction in family medicine. J. Med. Educ., 40, 370-375, 1965. (University of Miami School of Medicine, Fla.)

154. Carmichael, Lynn P. Preparation for family practice. Conn. Med., 32, 660-662, 1968. (University of Miami School of Medicine, Fla.)

IV. TRAINING IN FAMILY MEDICINE

A. General Reports (Cont.)

155. Citizens Commission on Graduate Medical Education. The graduate education of physicians. The report of the Citizens Commission on Graduate Medical Education: John S. Millis, Chairman, commissioned by the American Medical Association. Chicago, AMA, 1966. Popularly known as The Millis Report. 114 pp.

156. College of General Practitioners. Present state and future needs. J. Coll. Gen. Pract., 10, Reports from General Practice II, 1-56, July, 1965.

157. Darley, Ward. Medical education and comprehensive medical care. GP, 32, 166-171, 1965.

158. Fraser, R. C. Impressions of a young doctor entering general practice. J. Coll. Gen. Pract., 13, 372-377, 1967.

159. Harrell, George T. Education of the family physician. JAMA, 203, 495-498, 1968. (Pennsylvania State University, Department of Family and Community Medicine, Hershey, Pa.)

160. Harrell, George T. Why teach family medicine? J. Med. Educ., 45, 61-64, 1970. (Pennsylvania State University, Department of Family and Community Medicine, Hershey, Pa.)

161. Himmelwright, G. O. Standards for the new specialty of family practice. Maryland Med. J., 16, 131-133, 1967.

162. Hoheisel, Peter. Unique Midland Hospital program develops family practice physicians. Mich. Med., 66, 1172-1173, 1967. (Midland General Hospital, University of Michigan)

163. Lorrens, P. R. A pilot program in coordination of care between an urban teaching hospital and the community general practitioners. Amer. J. Public Health, 59, 60-64, 1969. (St. Luke's Hospital, New York)

164. McWhinney, J. R. General Practice as an academic discipline: reflections after a visit to the United States. Lancet, 1, 419-423, 1966.

165. Pellegrino, Edmund D. The generalist function in medicine. JAMA, 198, 541-545, 1966.

166. Truman, S. R. The Department of General Practice. Hosp. Progr., 46, 122-124, 1965.

IV. TRAINING IN FAMILY MEDICINE

A. General Reports (Cont.)

167. Wendel, H. F. New residency program in family medicine. Delaware Med. J., 41, 228, 1969. (Wilmington Medical Center, Wilmington, Del.)

168. Willard, William R. Rational responses to meeting the challenge of family practice. JAMA, 201, 108-111, 1967.

169. Willard, William R. The primary physician. J. Med. Educ., 44, 119-125, 1969.

170. Witten, C. L., Johnson, A. N., Michaelson, G. and Lollerhos, W. The core content of family medicine: a report of the Committee on Requirements for Certification. GP, 34, 225-246, Nov., 1966.

IV. TRAINING IN FAMILY MEDICINE

B. Training Programs Outside the United States

We have been impressed with the international current in the development of family practice training programs. In each of the references below, the countries surveyed appear in parentheses at the end of the listings.

171. Australian College of General Practitioners. Medical Education Committee of Council. Vocational training for general practice and the first college advanced training courses. Annals of General Practice, Education Series No. 1, March, 1966. 46 pp.

172. College of Family Physicians of Canada (Alberta Chapter). Pilot project for the development and evaluation of techniques for training in family practice. Curriculum. 1968. Available from Medical Education Office, Calgary General Hospital, Calgary, Alberta, Canada. 71 pp.

173. Eimerl, T. S. A general practitioner looks at Denmark. J. Roy. Coll. Gen. Pract., 14, 203-218, 1967.

174. Gaskell, P. G. A hospital and general practice combined training scheme in Scotland. Brit. J. Med. Educ., 1, 374-380, 1967. (Inverness, Scotland)

175. Horder, J. P. The general practitioner in Yugoslavia, Czechoslovakia and Israel: special vocational training. Lancet, 2, 123-125, 1965.

176. Horder, J. P. Role and training. J. Coll. Gen. Pract., 11, 117-134, 1966. (Yugoslavia, Czechoslovakia and Israel)

177. Hunter, A. T. Graduate training for family practice: experiences in a pilot program. Canad. Med. Ass. J., 98, 721-724, 1968. (St. Joseph's Hospital, London, Ontario, Canada)

178. Hutchinson, M. Group practice, ancillary help and government controls. J. Roy. Coll. Gen. Pract., 14, Suppl. 1, 1-67, 1967. (Israel, Australia, New Zealand and Canada.)

179. Huygen, F. J. A. Report on general practice in the Netherlands. In, Symposium on the Art and the Science of General Practice. J. Coll. Gen. Pract., 9, Suppl. 2, 13-19, 1965.

180. Jungfer, C. General practice: training and distribution. Med. J. Aust., 1, 932-933, 1969. (Australia)

IV. TRAINING IN FAMILY MEDICINE

B. Training Programs Outside the United States (Cont.)

181. Katsunuma, Haruo. The family doctor in the health plan (Japanese system). Med. J. Aust., 2, Suppl., 68-69, 1965. (Japan)

182. Khan, H. R. Responsibility of the family doctor in developing countries. Med. J. Aust., 2, Suppl., 64-67, 1965. (Pakistan)

183. Logan, R. F. and Eimerl, T. S. Case loads in hospital and general practice in several countries. Milbank Mem. Fund Quart., 43, 302-310, 1965. (Czechoslovakia, Germany, Yugoslavia, Spain, Italy, Switzerland, U. S. A., England, Scotland and Sweden)

184. McAuley, R. G. Family practice: a proposed solution to the problem of meeting the medical needs of the community. Canad. Med. Ass. J., 96, 1036-1039, 1967. (McMaster University, Hamilton, Ontario, Canada)

185. Medalie, Jack H., de Vries, A. and Shachor, S. Family medicine at the Tel Aviv Medical School. Lancet, 1, 979-981, 1969. (Israel)

186. Niyogi, A. K. and Dave, B. T. Training of interns in integrated general practice in the out-patient department of a teaching hospital. Brit. J. Med. Educ., 2, 187-190, 1968. (India)

187. Rorie, R. A. B. Scandinavian family care and psychiatry. J. Coll. Gen. Pract., 10, 54-61, 1965.

188. Staines, F. H. General practitioner services--organization and attitudes. Proc. Roy. Soc. Med., 61, 1065-1068, 1968. (Israel, New Zealand and Australia)

189. Stephen, J. General practice in Eastern Europe. Practitioner, 203, 86-93, 1969. (Bulgaria, Romania and Poland)

190. Swift, G. A course in vocational training for general practice in Wessex. Brit. J. Med. Educ., 2, 63-70, 1968.

191. Thomson, R. K. C., MacKenzie, Walter C. and Peart, A. F. W. A visit to the People's Republic of China. Canad. Med. Ass. J., 97, 349-360, 1967.

192. Velasquez, G. The general practitioner and the evolution toward "community medicine." Israel J. Med. Sci., 4, 656-664, 1968. (The Faculty of Medicine, Lexington, Ky.; Hacettepe Medical Center, Ankara, Turkey; Universidad del Valle, Cali, Colombia)

193. Whitfield, M. J. Training for general practice: result of a survey into the general practitioner trainee scheme. Brit. Med. J., 1, 663-667, 1966. (England and Wales)

V. INSTRUCTIONAL AND EVALUATIVE TECHNIQUES

Family medicine training has appeared at a time when there has been increasing interest on the part of medical educators in the fields allied to general education. For example, instructional strategies, especially those using the new technological facilities--see Dombal (1959) and Torkelson (1967)--have received a good deal of attention. Problems around evaluation have also been crucial, as teachers of physicians have begun to ask not only, "How can we train better doctors?" but also, "How can we measure to what extent we have succeeded, and how may the process be improved?"

194. Adler, Leta McK., Ware, J. E. and Enelow, A. J. Evaluation of "Programmed" instruction in medical interviewing. Los Angeles, Post-Graduate Division, Department of Psychiatry, University of Southern California, 1968. 105 pp.

195. Balint, Enid. A study of the doctor/patient relationship using randomly selected cases. J. Coll. Gen. Pract., 13, 163-173, 1967.

In this study 50 patients selected randomly from those presented by general practitioners in a Tavistock seminar were investigated and followed up over a period of time. The goals of the study were: (1) to study the doctor-patient relationship at the time of the first report; (2) to study the effect of the seminar discussion both on the doctor-patient relationship and on diagnostic concepts; (3) to observe when it is rewarding for the doctor to deepen or intensify his relationship with his patient, and (4) to study the correctness of the predictions made by the seminar group at the time of each report. The doctors often gained additional information about their patients through the seminar discussions, and sometimes felt guilty if their knowledge of their patients was incomplete. The author states, "I think this is because they feel that if they were really good doctors, they would know everything and there is an unwillingness to realize that the patient has something to do with the way he is treated and the medicine he is given." The evaluative summary is cautious. Participating doctors felt that although the treatment of their patients may not have changed, as a result of their altered way of looking at patients and formulating diagnoses, "there were certainly many fewer shattering things that had gone wrong with the families in their practices without their knowing it than would have happened before work started."

V. INSTRUCTIONAL AND EVALUATIVE TECHNIQUES

196. Balint, Michael. The structure of the training-cum-research seminars: its implications for future medicine. J. Roy. Coll. Gen. Pract., 17, 201-211, 1969.

The author summarizes the nature of the training-cum-research seminars as "discussion seminars on psychological practice." The research aims are to discover what the psychological problems in everyday general practice are, how to recognize and understand them, and how to use this knowledge and understanding to achieve an enhanced therapeutic effect on the patient. The differences between illness-centered medicine as it is taught in medical schools and practiced in university medical centers and patient-centered medicine as it occurs in general practice are discussed. The instructional events in the seminars are grouped under three categories: unlearning, relearning and learning. The doctor unlearns his unlimited belief in the traditional diagnosis and also changes his attitude toward medical history taking. Relearning involves the care with which information must be recorded concerning the patient, the visit, the patient's reactions, and what the doctor has discovered. Among the things which are learned, the most surprising is the fact that the doctor himself is the "most frequently prescribed drug in medical practice." The practitioner needs to discover what sort of drug he is, how he behaves, what doses are appropriate, etc. He learns also to listen and try to understand the meaning of what the patient is communicating rather than to ask questions and collect answers. Reports of several ongoing research projects in London are mentioned, including one on repeat prescription patients and one on work with patients in terminal phases of an illness.

197. Balint, M., Balint, Enid, Gosling, R. and Hildebrand, P. A study of doctors: mutual selection and the evaluation of results in a training programme for family doctors. Mind and Medicine Monographs No. 13. London, Tavistock Publications and New York, Lippincott and Co., 1966. 146 pp.

In this book the authors summarize their experience in teaching psychotherapeutic medicine to general practitioners (beginning in 1950) and their efforts to evaluate the effectiveness of this teaching. The introduction of a mutual selection interview as part of the admission procedure in the Tavistock Seminars is described. During this interview the psychiatrist and the practitioner usually agreed about whether it was worthwhile for the practitioner to enter the seminars. Before and after data support the effectiveness of this selection

V. INSTRUCTIONAL AND EVALUATIVE TECHNIQUES

197. Balint, M., et al. London, Tavistock Publications and New York, Lippincott and Co., 1966 (Cont.)

procedure. A classification scheme is presented for evaluation and description of various types of seminar participants. Also, there is a brief history of the evolution of the Tavistock Seminars and the rationale for the use of data from the teaching situation in the evaluation. 41 references.

198. Bogdonoff, M. D. New curricula and training for patient care. Arch. Intern. Med., 124, 507-509, 1969.

The author here considers the arguments for an accelerated curriculum and early specialization in medical education. His major point is that the question of adequate training is not necessarily a matter of time, but of how this time may be used to insure the development of professional excellence in handling the psychological and emotional as well as the medical aspects of the patient's illness. Bogdonoff feels that the essence of this kind of excellence can be stated as four "lessons" which have been learned from teaching experience: (1) Focused and continuous consideration of behavioral components of illness is a requisite for any program of medical education. (2) Precise techniques for developing disciplined awareness of the importance of the doctor-patient relationship and more effective utilization of this relationship must be formally emphasized. (3) The elements that enhance a physician's concern for another human being or inhibit such concern can be identified and reviewed within the structure of the medical education program. (4) Emulation of a senior staff "practicing what they are preaching" promotes a more effective pattern of learning than "evangelistic appeals." 8 references.

199. Charvat, J., McGuire, Christine and Parsons, V. A review of the nature and uses of examinations in medical education. Public Health Paper No. 36, Geneva, World Health Organization, 1968. 74 pp.

Anyone considering the use of examinations for evaluative or instructional purposes will find in this book a concise treatment of the important concepts in the area. Chapter 2 includes a consideration of the use of examinations in the clinical years of medical school and examinations associated with graduation and licensing. In Chapter 3 the authors consider examination methods in current use, including competence-measuring techniques, the role of curricular allocations, recommendations, grading systems, and the advantages and disadvantages of different types of examinations. In Chapter 4, New Developments in

V. INSTRUCTIONAL AND EVALUATIVE TECHNIQUES

199. Charvat, J., et al. Geneva, World Health Organization, 1968 (Cont.)

Examination Theory and Practice, the process approach, the use of critical requirements and new techniques for constructing a test, and new techniques for determining full range of professional competence are considered. New approaches to the reporting and analysis of examination data, the setting of standards of competence, and the training of examiners, are also discussed. 19 footnote references.

200. Dombal, F. T., de Hartley, J. R. and Sleeman, D. H. A computer-assisted system for learning clinical diagnosis. Lancet, 1, 145-148, 1969.

201. Dudley, H. A. F. Objects of objective tests: a theoretical and experimental analysis. Brit. J. Med. Educ., 3, 155-159, 1969.

202. Editors. The physician's education--can sabbaticals help? Canad. Med. Ass. J., 98, 1198-1200, 1968.

203. Elkinton, J. R. Self-assessment of medical knowledge. Ann. Intern. Med., 68, 247-249, 1968.

204. Froelich, Robert E. A course in medical interviewing. J. Med. Educ., 44, 1165-1169, 1969.

205. Froelich, Robert E. and Bishop, F. Marian. One plus one equals three. Med. Biol. Illus., 19, 15-18, 1969.

206. Gregory, Chas. F. Orthopaedics and the impact of learning theory. J. Med. Educ., 44, 777-783, 1969.

207. Harden, R. M., Dunn, W. R., Holroyd, C., Lever, Rosemary, Lindsay, Anne and Wilson, G. M. An experiment involving substitution of tape/slide programmes for lectures. Lancet, 1, 933-935, 1969.

208. Harshbarger, D. The professional workshop: myth and reality. Hosp. Community Psychiat., 19, 294-296, 1968.

209. Horder, J. P. Teaching psychosomatic medicine to young general practitioners. J. Psychosom. Res., 11, 101-106, 1967.

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210. Hubbard, J. H., Levit, Edythe J., Schumacher, C. F. and Schnabel, T. G., Jr. An objective evaluation of clinical competence: new technics used by the National Board of Medical Examiners. New Eng. J. Med., 272, 1321-1328, 1965.

This article describes the development of a new test of clinical competence sponsored by the National Board of Medical Examiners. 3,300 critical incidents from clinical practice, evenly divided between good and poor, were collected from 600 physicians. Nine main areas appropriate for testing emerged from these incidents. They were: history; physical examinations; tests and procedures; diagnostic acumen; treatment; judgment and skill in implementing care; continuing care; physician-patient relation, and the responsibilities of the physician. Using the information from the incidents, a technique of examination was constructed which the authors call "programmed testing." Films and still photographs are used to simulate the clinical situation. The doctor is presented with information about the patient and with a number of choices. At each point in the examination, his decision makes available to him additional information both about the patient and the effect of his (the doctor's) therapeutic and diagnostic moves. The authors feel that the skills and ability to establish rapport with a patient or to assume proper responsibility for the welfare of a patient were not adequately tested by this technique, but on the other hand, reliability measures were impressive. "The introduction of these testing methods has added new dimensions to an objective, reliable evaluation of clinical competence." 6 references.

211. Levine, H. G., McGuire, Christine and Nattress, L. W., Jr. The validity of multiple choice achievement tests as measures of competence in medicine. Amer. Educ. Res. J., 7, 69-82, 1970.

This study reports a collaboration between the American Board of Orthopedic Surgery and the Center for the Study of Medical Education at the Illinois College of Medicine to investigate the reliability and validity of techniques for assessing professional competence. Two testing programs were investigated: board certifying examinations and diagnostic in-training examinations administered to all residents in orthopedic surgery in the United States and Canada. In both studies the scores on the multiple-choice tests were correlated with pooled ratings of two or more supervisors on ten performance factors: fund of information; problem-solving ability; ability to gather clinical information; clinical judgment;

V. INSTRUCTIONAL AND EVALUATIVE TECHNIQUES

211. Levine, H. G., et al. Amer. Educ. Res. J., 7, 69-82, 1970 (Cont.)

skill in surgical procedures; ability to relate effectively to patients; ability to relate effectively to colleagues; professional habits and attitudes; ability to assume responsibility for continuing care of patients; effectiveness in emergency situations, and overall competence. Residents' scores were ranked; candidates for the specialty boards were scored on "absolute standard of competence in practicing the profession." Results of the in-service examinations revealed differences in the expected direction, i.e., mean scores for groups at different levels of training increased over the four years of orthopedic residency training. Correlation of multiple-choice test scores with supervisors' ratings were low but in the expected direction. The multiple-choice scores related more closely to ratings of cognitive components of competence than to ratings of skill and affect. The authors conclude that the multiple-choice technique measures certain facets of competence in orthopedic surgery. Some attributes such as deductive reasoning and judgment related to the ability to avoid errors in diagnosis and treatment are not measured by this technique. 10 references.

212. Levinson, Daniel. Teaching the diagnostic process. J. Med. Educ., 43, 961-968, 1968.

The author delineates two perspectives for teaching the diagnostic process: the dynamic, a descriptive approach, and the genetic, an approach oriented toward etiology. He relates these perspectives to the three basic techniques for obtaining information about the illness, i.e., questioning, examining, and testing the patient. The emphasis in this article is less upon the strictly deductive and cognitive aspects of making a diagnosis and more upon careful description and adequate use of all kinds of information about the patient and his illness. The author points out that much of diagnostic observation and thinking takes place intuitively as a result of experience. "The less experienced a clinician is, the more he will find the diagnostic approach outlined here to be of value." There is no doubt, however, that arriving at a diagnosis can be a challenge for the most experienced physician. "To approach each patient with a careful and rational diagnostic perspective is the best hope not only of avoiding error but also of making new observations about disease. Such an approach often makes the difference between a routine, uninteresting practice and a challenging and stimulating medical career." 6 references.

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213. Long, Lillian D. The evaluation of continuing education efforts. Amer. J. Public Health, 59, 967-973, 1969.

214. McGuire, Christine H. Medical education. Part I. A scientific approach to problems of professional assessment. Canad. Med. Ass. J., 100, 593-598, 1969.

215. Miller, George E. The study of medical education. Brit. J. Med. Educ., 3, 5-10, 1969.

In this article, Dr. Miller describes three classes of contributors to the research literature in medical education: the impressionists, the taxonomists, and the investigators. "The impressionists are by far the most numerous and the most difficult to deal with. For these are men of good will who think seriously about the problems of medical education, reflect deeply upon what they have observed or done, and are inclined to develop generalizations from this experience despite the sampling that has rarely been adequate to justify generalization." The taxonomist "seems to reject hypotheses as though their generation would color his vision. Instead he proceeds to accumulate, classify, and annotate information about educational programs with vigor and often with considerable imagination." Educational investigators define a problem or set a hypothesis, gather data specifically designed to test that hypothesis, and employ their results to evoke change when change is indicated. They continue their systematic studies sufficiently long to determine whether the change made any difference. When most effective, such investigators assist teachers and learners to clarify and refine educational objectives which may be seen only dimly, aid them in selecting or creating instructional materials or learning experiences that are consistent with those objectives, and work with them in assembling reliable and representative data from which they may judge whether the learning objectives have been achieved. Dr. Miller points out that such systematic study of medical education requires professionally qualified educational research staffs and mentions a series of educational offerings at the University of Illinois designed to encourage the development of such investigators.
3 references.

216. Miller, S. J., Davidson, C. S. and Peterson, O. L. The purpose and problems of participant observation in the study of graduate medical education. J. Med. Educ., 40, 894, 1965.

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217. Odum, Guy L. Neurological surgery and the assessment of accomplishment. J. Med. Educ., 44, 784-790, 1969.

218. Pearson, R. J. C., Eimerl, T. S. and Byrne, P. S. Medical students and general practice. Lancet, 1, 81-83, 1968.

219. Peterson, O. L. Attributes of lifelong competence in medical practice. JAMA, 198, 765-766, 1966.

220. Pratt, Philip C. and Ingersoll, Ralph W. A method for increasing the reliability and validity of multiple-choice examinations. J. Med. Educ., 43, 1238-1243, 1968.

221. Saunders, Richard H. Use of a special examination designed with specific reference to curriculum content. J. Med. Educ., 42, 935-937, 1967.

222. Swift, G. Postgraduate preparation for general practice. Brit. Med. J., 2, 595-597, 1965.

223. Torkelson, L. O. and Romano, M. T. Self-confrontation by videotape. JAMA, 201, 773-775, 1967.

224. Wagner, Henry N. Videotape in the teaching of medical history-taking. J. Med. Educ., 42, 1055-1058, 1967.

225. Williams, Christopher P. S. and Bergman, Abraham B. Teaching pediatrics in practitioners' offices. Clin. Pediat., 6, 451-453, 1967.

226. Williamson, J. W., Alexander, M. and Miller, G. E. Continuing education and patient care research: physician response to screening test results. JAMA, 201, 938-942, 1967.

This article describes an example of the patient-care-deficit approach to continuing medical education. The approach takes as its starting point some recognizable deficiency in patient care and proceeds to an attempt to remedy this by education. In a 260-bed community hospital, the authors studied physician responses to three routine admission tests--urine analysis, fasting blood glucose, and hemoglobin. Methods used for obtaining records of physicians' responses and for classifying them are given in detail. In December, 1963, 387 of the admission screening tests were normal, and only five physician responses to these tests were classified as "minimum adequate." There was unanimous

V. INSTRUCTIONAL AND EVALUATIVE TECHNIQUES

226. Williamson, J. W., et al. JAMA, 201, 938-942, 1967 (Cont.)

agreement among the staff that this was a serious problem and a workshop was organized to consider the results. Improvement in performance was to be the responsibility of each physician. Two follow-up evaluations of performance in the year following revealed that physician responses were essentially the same as they had been before the educational conference. Additional reminders including a technique of placing a fluorescent tape on the chart over the laboratory slip produced some improvement. The authors conclude: "Since educational effects are often short-lived, a continuing cyclic effort seems essential if desired levels of performance are to be achieved and maintained."
5 references.

227. Zabarenko, Lucy, Pittenger, R. A. and Zabarenko, R. N. Primary medical practice: a psychiatric evaluation. St. Louis, Mo., Warren H. Green, Inc., 1968. 271 pp.

The purpose of this study was to assess the effectiveness of courses in psychotherapeutic medicine by observing general practitioners at work in their offices. Four of the practitioners observed attended seminars in psychotherapeutic medicine, and these practitioners were observed before, during, and after the course work. Four comparison practitioners with no interest in the seminars and roughly matched for age, sex, race, and type of practice, were also observed. Each practice was found to be surprisingly unique and each is described in detail. In Chapter 4, Medical Styles, a number of typical doctor-patient transactions are described. There are three for which there is adequate evidence: the screening transaction, the procrustean transaction, and the crisis situation. There are two for which there is some evidence: the adynamic transaction and the faltering transaction. Three are hypothesized transactional styles: the non-patient transaction, the no-illness situation, and the psychological transaction. No demonstrable changes could be found in the practices where the physician had taken course work.
27 tables. 252 references.

VI. PSYCHOTHERAPEUTIC ASPECTS OF FAMILY PRACTICE

The end of World War II marked the beginning of greatly increased interest on the part of physicians in the psychological aspects of their work. Thus, it has been possible for programs in family medicine to draw on a reservoir of literature both in the areas of training and research.

228. Balint, Michael. The pyramid and the psychotherapeutic relationship. Lancet, 2, 1051-1054, 1961.

229. Balint, Michael. Training for psychosomatic medicine. In, Advances in Psychosomatic Medicine, Vol. 1, A. Jores and H. Freyberger (Editors). New York, Robert Brunner, 1961. Pp. 167-179.

230. Balint, Michael. Psychoanalysis and medical practice. Int. J. Psychoanal., 47, 54-62, 1966.

231. Balint, Michael and Balint, Enid. Psychotherapeutic techniques in medicine. London, Tavistock Publications, 1961. 236 pp.

232. Becker, Alvin (Editor). The general practitioner's role in the treatment of emotional illness. Proceedings of a symposium held at Boston State Hospital, Boston, Mass. Springfield, Ill., Chas. C. Thomas, 1968. 101 pp.

This symposium is organized into two sections. Part 1, "Current Stresses on the General Practitioner," includes among other articles: an account of a research project investigating psychiatry in general practice by Leonard Weiner, Ph.D.; a list of seven psychiatric skills the general practitioner should possess by Dr. William J. Haggert; two presentations by Dr. Milton Greenblatt and Dr. William A. Barclay, a guest from Australia, on the use of psychopharmacological methods in general practice psychiatry, and discussions on alcoholism, the usefulness of psychiatric house calls and the "20-minute hour." Part 2, "Possible Solutions," contains an historical account of the development of postgraduate psychiatric education for the general practitioner by Alvin Becker, M.D., and Jacob Swartz, M.D., and a description of the extent and development of these educational efforts up to the present time. In "Promising Research and Demonstration Programs on the National Scene," Phillip Solomon, M.D., discusses ongoing research efforts including those aimed at evaluating and improving the effectiveness of educational techniques. "The Relationship of General Practitioners to the Emerging Comprehensive Community Mental Health Centers" is considered by James Osberg, M.D. 54 references.

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233. Bogdonoff, Morton D. Psychiatric training for physicians in internal medicine. Ann. Intern. Med., 67, 900-902, 1967.

This article describes a training program in the Division of Behavioral Medicine at Duke University Medical School. The program has been conducted for seven years, is housed in the Department of Medicine, and is staffed by members of the Department of Medicine and Psychiatry with the cooperation of the Departments of Psychology and Sociology. The purpose is described as: "To equip the internist with a stronger sense of security regarding the components of human behavior that relate to medical illness." The author's observations at the end of seven years of experience are: (1) Because the learning process is so slow, the faculty "need dogged commitment to the task at hand." (2) Input from new research must be part of the training program. (3) Almost all medical students receive some exposure to the program, but only six to ten students invest any considerable effort during the course of a year. (4) "The trainees will use as their model a physician interested in behavior; they will invariably reject a behavioral theorist who happens to be interested in patients." 2 references.

234. Burvill, P. W. and Bamford, J. A. C. General practitioners and psychiatry: report of a survey. Med. J. Aust., 1, 1014-1016, 1968.

235. Castelnuovo-Tedesco, Pietro. The 20-minute "hour": an experiment in medical education. New Eng. J. Med., 266, 283-289, 1962.

236. Clyne, Max B. The three faces of Joan. Lancet, 1, 1270-1272, 1964.

237. Daugherty, Robert I. The role of the general practitioner. Psychosomatics, 8, 259-260, 1967.

238. Downes, Jean and Simon, Katherine. Characteristics of psychoneurotic patients and their families as revealed in a general morbidity study. Psychosom. Med., 15, 463-476, 1953.

239. Dwyer, Thomas F. The development of a psychiatric training program for medical house officers. J. Med. Educ., 45, 11-20, 1970.

VI. PSYCHOTHERAPEUTIC ASPECTS OF FAMILY PRACTICE

240. Ehrenwald, J. and Kloth, E. General practitioner in community psychiatry: experiment treatment project. New York J. Med., 69, 1739-1743, 1969.

241. Enelow, A. J. and Wexler, M. Psychiatry in the practice of medicine. New York and London, Oxford University Press, 1966. 355 pp.

242. Engel, George L. Medical education and the psychosomatic approach: a report on the Rochester experience 1946-1966. J. Psychosom. Res., 11, 77-85, 1967.

This article summarizes 20 years of experience in one of this country's most outstanding programs in education for psychosomatic medicine. The author, an internist and psychiatrist, states that: "The role of mind and brain in the regulation of somatic processes and organismal adjustment will prove to be the most important basic discipline to emerge in the second half of the 20th century." An important aspect of the Rochester Program is the use of medical liaison groups in departments other than psychiatry and within departments. The undergraduate medical school program includes a 72-hour course in psychiatry in the freshman year, and 120 hours in psychiatry in the second year. A general clerkship in the first 15 weeks of the third year is designed to provide the students with graduated instruction in basic methods of examination and observation. The graduate program in psychosomatic medicine accepts only residents who have had at least two years of residency in medicine, psychiatry, pediatrics, or obstetrics and gynecology, or who have had three or more years of experience. There have been 51 fellows in this program since 1946. Thirty-three have remained full time on the staff and seven are part-time members. 9 references.

243. Gosling, R. H., Miller, G. H., Woodhouse, D. and Turquet, P. M. The use of small groups in training. London, Codicote Press, 1967. 144 pp.

Since small groups are frequently used in medical education, this dynamic consideration of the subject may be of special interest. The specific kind of groups used as examples is that in which general practitioners present cases from their practices. The authors discuss a number of aspects of seminars, including the reporting doctor and the group, transference and its interpretation, and the use of a

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243. Gosling, R. H., et al. London, Codicote Press, 1967 (Cont.)

group for the acquisition of skills. As part of their consideration of the role of the leader, they state that one of his functions is to listen to the discussion in such a way as to guide its course to provide maximum learning opportunities. When a case is being presented, the leader should be able to aid the presenter in assessing its impact on the group. Among relationships considered in the seminar are those between: (1) the reporting doctor and the group; (2) the reporting doctor and the seminar leader; (3) the reporting doctors among themselves; (4) the seminar leader and the group, and (5) the group and the larger society of which it is a part. 28 references.

244. Group for the Advancement of Psychiatry. Committee on Public Education. Medical practice and psychiatry: the impact of changing demands. GAP Report No. 58. New York, Group for the Advancement of Psychiatry, 1964. Pp. 327-369.

245. Hopkins, Philip. Psychosomatic disorders. In, The Encyclopaedia of General Practice, Vol. 5, G. F. Abercrombie and R. M. S. McConaghey (Editors). London, Butterworths, 1964. Pp. 168-196.

246. Kedward, H. B. and Cooper, B. Neurotic disorders in urban practice: a three-year follow-up. J. Coll. Gen. Pract., 12, 148-163, 1966.

During 1961-1962 a survey was carried out in 46 metropolitan practices in England. The results show that of 15,000 persons at risk, approximately 2,000 had consulted at some time during the year with a medical condition regarded by the doctor as largely of a psychiatric nature. In this article a follow-up study of a sample of 275 patients is described. The follow-up was done three years after the date of the original consultation. Of the sample, 77.2% were able to be traced, that is, they were still registered in the survey practices in 1964. There are tabular presentations of data giving information about diagnostic groupings, therapeutic action, and patient sex. The authors found that only a small fraction of the neurotic patients had been referred to psychiatrists. A few of these patients had had psychiatric treatment before the original survey year; none afterward. In 85% of neurotic patients, psychiatric referral was never considered. The general practitioners'

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246. Kedward, H. B. and Cooper, B. J. Coll. Gen. Pract., 12, 148-163, 1966 (Cont.)

assessments of the patients' conditions were: 28.4% recovered, 24% improved, and 47.6% unimproved or worse. Psychiatric associated conditions and depressive reactions were frequent diagnoses in the recovered or much improved group; anxiety states and personality disorders were frequent in the group showing no improvement. There was no significant sex or marital status differential related to outcome. 5 tables. 7 references.

247. Kreitman, N., Pearce, K. I. and Ryle, A. The relationship of psychiatric, psychosomatic and organic illness in a general practice. Brit. J. Psychiat., 112, 569-579, 1966.

This article contains not only a research report of substantial significance, but also a useful consideration of methodology. The hypothesis tested was that during a phase of illness, an individual shows an increased susceptibility to all forms of illness regardless of nature or etiology. The sample of patients included 124 women and 115 men within the age range of 15 to 60 years representing an approximate 30 per cent sample of patients continuously attended by one general practitioner for a minimum of seven years. Six diagnostic categories were devised, and an attempt was made to control for the effects of age sex, and duration of observation. The data has been analyzed by scattergrams and contingency tables, and the authors have used Fisher's Exact Probability Tests to determine the possibility that the results could have occurred by chance. The conclusion reached is that the hypothesis of a possible concordance between physical and mental illness was not confirmed, but the authors stress that this may have to do with the general way in which this hypothesis was posed. "Studies correlating specific somatic and psychological variables seem highly rewarding, but it would appear that general theories of illness must await the accumulation of a great deal of such data." 4 tables. 21 references.

248. McCorkell, W. J. and McKerracher, D. G. The family doctor and the psychiatric ward. Mental Hosp., 13, 300-302, 1962.

249. McKerracher, D. G. Trends in psychiatric care. Ottawa, Canada, Queen's Printer, 1966. 256 pp.

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250. McKerracher, D. G., Smith, C. M., Coburn, E. and McDonald, I. M. General-practice psychiatry: two Canadian experiments. Lancet, 2, 1005-1007, 1965.

251. Main, T. F. The ailment. Brit. J. Med. Psychol., 30, 129-145, 1957. (For annotation, see item 41.)

252. May, A. R. Participation of general practitioners in community psychiatry. Brit. Med. J., 2, 168-171, 1968.

253. Meldman, J. J. and Rossi, Jean J. A psychopathology laboratory in a general hospital: method for teaching psychosomatic medicine. Psychosomatics, 10, 105-110, 1969.

254. Monroe, Russell R. Techniques for evaluating the effectiveness of psychiatric teaching. Amer. J. Psychiat., 122, 61-67, 1965.

255. Ryle, A. Neurosis in the ordinary family. London, Tavistock Publications and Philadelphia and Toronto, Lippincott Co., 1967. 156 pp.

In this research a psychiatrist, a general practitioner, and psychiatric social worker studied a group of 112 families from a general practice. The sample was from a working class section of London; each marriage had been of at least six years' duration; 13 of the families studied had just one parent. Data were collected in interviews averaging about four hours in length, conducted by the practitioner and the psychiatric social worker. The families also completed the Cornell Medical Index and Parent Attitude Questionnaires. Among the chapter headings are: The Parents' Childhoods; Neurosis in the Parents and its Relation to Childhood Social Factors; The Parents' Marriages; Child-Rearing Practices and their Relation to Other Parental Attributes; Psychological Disturbance in the Children; Parental Factors Associated with Disturbance in the Children, and Family Diagnosis. The general practitioner felt that major therapeutic effects (with neurotics) were distinctly rare, though support may have prevented deterioration in some cases. "The main effect of experience was to make me more cautious in my response to patients' psychiatric demands, and less ambitious in my therapeutic aims." The authors recommend family-centered treatment with the concentration of main psychiatric resources upon young individuals especially those in late childhood, adolescence, and early adult life. 32 tables. 104 references.

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256. Shepherd, M., Cooper, B., Brown, A. C. and Kalton, G. W. Psychiatric illness in general practice. London, Oxford University Press, 1966. 220 pp.

This book reports a program of research into the problems of psychiatric illness in general practice conducted over a period of years at the Institute of Psychiatry of London University. The principal aims of the project were to obtain reliable information on the amount and nature of psychiatric morbidity encountered in the setting of general practice, and to study the factors by which the general practitioner is influenced in identifying and treating psychiatric illness. Among the substudies reported are the following: (1) To check the practitioners' clinical assessments, psychiatric interviews were conducted on identified cases. (2) A separate investigation of a sample of patients who had not attended a surgery for a number of years although registered was conducted to investigate the possibility that much psychiatric illness might be unknown to the doctor. (3) A detailed study of the relationship between psychiatric and general morbidity was made. Results and methodology are reported in detail and the organization of the report makes it possible to locate specific studies and their results as these are of interest. 50 tables. 168 references.

257. Shochet, Bernard R. and Lisansky, Ephraim T. New dimensions in family medicine. Psychosomatics, 10, 88-93, 1969.

258. Stein, Calvert. Practical psychotherapy in nonpsychiatric specialties. Springfield, Ill., Chas. C. Thomas, 1969. 300 pp.

259. Stratas, Nicholas E. and Cathell, James L. Psychiatric consultation with community physicians. Hosp. and Community Psychiat., 17, 202-204, 1966.

260. Sylph, Judith, Kedward, H. B. and Eastwood, M. R. Chronic neurotic patients in general practice. J. Roy. Coll. Gen. Pract., 17, 162-170, 1969.

261. Symposium on psychiatry in general practice, September, 1967. J. Roy. Coll. Gen. Pract., 17, Suppl. 3, 1-55, 1969.

262. Walton, H. J. Effect of the doctor's personality on his style of practice. J. Roy. Coll. Gen. Pract., 16, 113-126, 1968.

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263. Watts, C. A. H., Cawte, E. C. and Kuenssberg, E. V. Survey of mental illness in general practice. Brit. Med. J., 2, 1351-1359, 1964.

Mentally disabled patients in 261 practices (with over a million persons at risk) located in England, Scotland and Wales, were included in this one-year survey which began November, 1961. Seven mutually exclusive categories were set up to cover degrees of disablement ranging from those persons who because of a psychiatric illness had been unable to work for a year or more to those suffering from an acute confusional state which had lasted for more than 24 hours and had been treated at home or in a psychiatric hospital. Results are analyzed by sex, diagnosis, geographic location, age, and chronicity. Overall, about 0.9 per cent of the sample studied in the survey were regarded as severely mentally disabled. The authors conclude also that for every patient in a mental hospital there are more than two in the community who are disabled in some sense. 8 references.

264. Wear, L. E. Patterns of patient communication. J. Coll. Gen. Pract., 11, 49-53, 1966.

265. Williams, D. L. Social factors in emotional disorders in general practice. J. Coll. Gen. Pract., 9, 215-225, 1965.

266. Wylan, Louise and Weiner, Leonard. Involving general practitioners in community mental health. Hosp. Community Psychiat., 18, 255-258, 1967.

267. Zabarenko, Lucy, Pittenger, R. A. and Zabarenko, R. N. Research into psychotherapeutic aspects of general practice: problems and progress. J. Roy. Coll. Gen. Pract., 14, 140-162, 1967.

268. Zabarenko, Lucy, Pittenger, R. A. and Zabarenko, R. N. Primary medical practice: a psychiatric evaluation. St. Louis, Mo., Warren H. Green, Inc., 1968. 271 pp. (For annotation, see item 227.)

269. Zabarenko, R. N., Zabarenko, Lucy and Pittenger, R. A. The psychodynamics of physicianhood. Psychiatry, 33, 102-118, 1970.

270. Zinberg, Norman E. (Editor) Psychiatry and medical practice in a general hospital. New York, International Universities Press, 1964. 364 pp.